Michigan's 2017 Essential Health Benefits Benchmark Plan: Executive Report

July 1, 2015

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Executive Summary

The Michigan Department of Insurance and Financial Services (DIFS) presents this Executive Report on Michigan's Essential Health Benefits Benchmark Plan. This report contains a summary of the essential health benefits (EHB) requirements as well as information regarding the selection and supplementation of an EHB benchmark plan.

As in the EHB benchmark selection in 2012, DIFS' benchmark plan recommendation for 2017 reflects the need to provide Michigan consumers with a benchmark plan that offers comprehensive coverage and affordable rates.

DIFS recommends that the Priority Health HMO plan be selected as Michigan's base-benchmark plan. In making this recommendation, DIFS adhered to certain guidelines; namely, that the recommended plan should:

- Include coverage for all Michigan-mandated services; and
- Provide comprehensive coverage while maintaining affordability.

In addition, DIFS took into consideration the following:

- Public comments;
- Scope and duration limitations for covered benefits; and
- Consistency with the current benchmark plan.

The Priority Health HMO plan offers a wide range of benefits and will provide an excellent framework for all individual and small group plans offered in Michigan for plan year 2017. In addition, DIFS recommends that the Federal Employee Dental and Vision Insurance Program (FEDVIP) pediatric vision plan and the MIChild dental plan again be selected to supplement the Priority Health HMO base-benchmark plan.

Next: Overview of Essential Health Benefits →

Overview of Essential Health Benefits

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA) was enacted on March 23, 2010. The ACA requires that all non-grandfathered[1] health insurance plans offered in the small group and individual markets[2], both on and off the Exchange, provide benefits in ten required EHB categories. The ten EHB categories are:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services (including behavioral health treatment),
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services and chronic disease management, and
- pediatric services (including oral and vision care).[3]

Each State is required to select an EHB "base-benchmark plan": a plan that will serve as a reference plan, reflecting both the scope of services and any quantitative limits on those services by a "typical employer plan" in the State.[4] As of January 1, 2014, any small group or individual market plan offered in the State must be "substantially equivalent" to the benchmark plan in both the scope of benefits offered and any limitations on those benefits, such as visit or duration limits.

A base-benchmark plan must be supplemented in any categories in which it is deficient. In general, a base-benchmark plan must be supplemented if it is deficient in any of the following circumstances:

- it completely lacks any benefit in any of the ten EHB categories;
- it lacks certain women's wellness benefits;
- it does not provide coverage for all current U.S. Preventive Services Task Force Recommendations (categories A and B);[5]
- it does not provide all required pediatric preventive services;

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[1] A grandfathered plan is one that was in existence on March 23, 2010.

[2] Grandfathered plans, large group plans, and self-insured employer plans are not required to offer EHBs, although many large group and self-insured plans already offer services in most, if not all, EHB categories. Although the plans are not required to offer EHBs, any EHBs they do offer may not have annual or lifetime dollar limits.

[3] 42 USC § 18022(b)(1)(A)-(J).

[4] 42 USC § 18022(b)(2)(A).

[5] Current USPSTF recommendations may be viewed at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

- it does not cover habilitative services and devices pursuant to the definition adopted by the state;
- it lacks pediatric oral and vision services;
- it fails to meet certain drug formulary requirements;
- its benefit design violates the ACA's prohibition on discrimination;
- it does not comply with mental health parity requirements as set forth in the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and implementing regulations.

A more detailed explanation of the supplementation process is on pages 7-10 of this report.

Next: The Base-Benchmark Plan Selection Process →

The Base-Benchmark Plan Selection Process

Federal regulations require each State to select its EHB base-benchmark plan from among the following ten options:

- the largest plan in each of the three largest small group products in the State by enrollment;
- the three largest State employee health plans by enrollment;
- the three largest federal government employee options by enrollment; and
- the largest HMO plan offered in the State's commercial non-Medicaid market by enrollment.[6]

In order to identify the largest small group plans by enrollment, the largest state employee plan, and the largest insured commercial non-Medicaid HMO, DIFS obtained enrollment data from issuers for the first quarter of 2014. From this data, DIFS identified the largest plans in each of the three State categories. The federal Center for Consumer Information and Insurance Oversight (CCIIO) provided information regarding the federal government employee plans. In addition, CCIIO provided DIFS with its determination of the largest three small group products in Michigan.

Based on the enrollment data provided by the federal government and by issuers, Michigan's ten benchmark plan candidates for plan year 2017 are:

- The largest plan in any of the three largest small group products in the State by enrollment: *BCBSM Community Blue PPO, BCBSM Simply Blue*[7]*, Priority Health HMO.*[8]
- The three largest State employee health plans by enrollment: *BCBSM (self-insured); PHP (HMO); Priority Health (HMO)*.
- The three largest Federal Employees Health Benefit Program (FEHBP) options by enrollment: *FEHBP BCBS Standard Option; FEHBP BCBS Basic Option; FEHB GEHA Standard Option*.
- The largest HMO plan offered in the State's commercial market by enrollment: *Priority Health HMO*.

It is important to note that the three small group products and the HMO plan are all "transitional" or "early renewal" plans. In 2013, DIFS allowed certain plans to remain in force

[6] 45 CFR § 156.100(a).

[7] See "Essential Health Benefits: List of the Largest Three Small Group Products By State—Revised," (May 19, 2015). There is one discrepancy between CCIIO's list and DIFS' list: CCIIO reported that the BCBSM "Simply Blue HSA with Drug" product was the second largest small group product. However, the actual second largest small group product is BCBSM's Simply Blue. The discrepancy is due to a transposed digit in the two plans' identification numbers, but does not affect the base-benchmark plan analysis because the two plans' benefits are identical.

[8] The Priority Health HMO plan occurs twice in Michigan's list because it is both the largest HMO plan and one of the three largest small group products. This Priority Health HMO plan is not the same Priority Health HMO plan that was selected as the EHB benchmark plan in 2012, although the plans are substantially similar. See p. 14, n. 32, below.

or to renew early for a limited period of time in order to provide issuers and consumers a transitional period to comply with ACA-related reforms. In response to this flexibility, a significant number of non-ACA-compliant plans remained in force during 2014. As a result, the three largest small group plans and the largest commercial HMO plan during the first quarter of 2014 were all "transitional" or "early renewal" plans, and thus not fully ACA-compliant. This is why, for example, several plans impose visit limits on mental health services—a practice that is no longer permissible as of 2014.

DIFS obtained plan documents from the issuers for each of the above-listed base-benchmark plan candidates. DIFS staff reviewed the plan documents and compiled the information into a chart to allow for a comparison of benefits and any scope or duration limitations. This chart is included in this report at Appendix B. The chart does not include information on medical management techniques, provider networks, cost-sharing, or similar items because those plan features are not part of the EHB definition and are not required to be incorporated by other plans adopting the EHB benchmark benefits.[9]

Next, DIFS provided advance copies of the charts to the issuers whose plans were listed in the chart. These issuers provided comments and additional information, which were incorporated into the final version of the chart.

The final chart, with links to plan documents, was posted on DIFS's website for public comment on May 15, 2015. From May 15, 2015 through June 5, 2015, DIFS accepted and reviewed public comments on the EHB chart through a dedicated email address accessible via DIFS's website.

Next: Comparing Michigan's Base-Benchmark Plans →

[9] Non-quantitative limitations (e.g., pre-authorizations, medical case management) are not part of the benchmark plan. 77 Fed. Reg. 42658, 42660 (July 20, 2012).

Comparing Michigan's Base-Benchmark Plans

Except in certain limited circumstances, a State must take its chosen base-benchmark plan "as is." In other words, all of the base-benchmark plan's covered services, quantitative limitations, and exclusions become the benchmark for all individual and small group health plans offered both on and off the Exchange.

It is important to note that the base-benchmark plan is a "floor," and does not prohibit issuers from adding benefits or altering certain benefit limitations, so long as those changes do not result in fewer benefits being offered.

As described above, DIFS compared the benefits covered by each of the ten benchmark plan options. In analyzing the potential costs associated with certain benefits, DIFS relied on the report provided in 2012 by Wakely Consulting Group, an actuarial and health care consulting firm, which provided estimates of the premium impact of certain benefits. DIFS also considered the differences between the previous base-benchmark plan and the new base-benchmark plan candidates. The Wakely study identified premium differences for certain benefit categories.[10] DIFS staff compared the plans in the context of these cost estimates and, as was the case in 2012, determined that the Priority Health HMO plan would likely be the least costly, particularly in the high-cost categories of adult dental, infertility, and physical therapy/occupational therapy/speech therapy.

DIFS' analysis resulted in the following conclusions:

- All plans (including the federal FEHBP plans) include all Michigan-mandated benefits.
- All plans would require supplementation in at least one area (most commonly, pediatric dental and vision care and habilitative services and devices).
- Notable variations in particular covered services included: visit limits for rehabilitative services; hearing aids; infertility treatments; adult dental; private duty nursing; chiropractic care; and non-emergency care when traveling outside of the United States.
- Many base-benchmark plan candidates, because they were issued prior to 2014, did not provide mental health benefits at parity with medical/surgical benefits. However, because all plans would have to be supplemented to comply with the MHPAEA, lack of parity was not a factor weighing against the selection of any particular plan. Similarly, the fact that a particular plan had combined limits for rehabilitative and habilitative services was not considered to weigh against that plan because the selected plan will not be permitted to have combined limits.

Next: Supplementing the Base-Benchmark Plan →

[10] See p. 12 of the Wakely study, which may be viewed here.

Supplementing the Base-Benchmark Plan

The ACA requires certain benefits to be included as part of the EHB for all plans:

- benefits in all ten EHB categories;
- current U.S. Preventive Services Task Force (USPSTF) Recommendations (categories A and B);[11]
- routine immunizations;[12]
- other evidence-informed preventive care and screenings for women set forth in guidelines supported by the Health Resources and Services Administration;[13]
- evidence-informed pediatric preventive care and screenings for provided for in guidelines supported by the Health Resources and Services Administration;[14]
- habilitative services and devices;[15]
- pediatric oral and vision services;[16]
- mental health parity requirements as set forth in the MHPAEA[17]; and
- prescription drug benefits.[18]

As a result, if the selected base-benchmark plan does not include any of these benefits, the State must supplement the base-benchmark plan accordingly.

Missing or Deficient Categories and Benefits

If a selected base-benchmark plan does not contain any benefits whatsoever in any one or more of the EHB categories, the State is required to supplement the benchmark by "borrowing" missing benefits from one or more of the other benchmark plan options. An exception to this rule is that a plan may choose not to offer pediatric oral services if a stand-alone dental plan that covers those services as defined by EHB is offered through the same Exchange.

Preventive Services

A plan must cover, without cost-sharing, all evidence-based items and services that have a rating of "A" or "B" in the current USPSTF recommendations with respect to the individual involved, except in the case of the USPSTF recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009. If the base-benchmark plan does not cover all recommended services and items, it must be supplemented to do so.

[11] 42 USC § 300gg–13(a)(1); 45 CFR 147.130(a)(1)(i). See http://www.uspreventiveservicestaskforce.org/BrowseRec/Index for a list of current USPSTF A and B recommendations.
[12] 42 USC § 300gg–13(a)(2); 45 CFR 147.130(a)(1)(ii).
[13] 42 USC § 300gg–13(a)(4); 45 CFR 147.130(a)(1)(iv).
[14] 42 USC § 300gg–13(a)(3); 45 CFR 147.130(a)(1)(iii).
[15] 42 USC § 18022(b)(1)(G).
[16] 42 USC § 18022(b)(1)(J).
[17] 42 USC § 18031(j); 45 CFR 147.160.
[18] 42 USC § 18022(b)(1)(F); 45 CFR 156.122.

HHS has recently issued new guidance on preventive services.[19] This guidance includes, among other things, certain requirements regarding contraceptive coverage, as follows:

- Issuers and plans must cover, without cost-sharing, at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women in its current Birth Control Guide.[20]
- Within each of the 18 methods, issuers may utilize reasonable medical management techniques. However, issuers must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual or a provider (or other individual acting as a patient's authorized representative).
- If an individual's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the issuer must cover that service or item without cost-sharing.

Pediatric Benefits Other Than Vision and Dental

The Health Resources and Services Administration supports the guidelines issued by Bright Futures/American Academy of Pediatrics. EHB-compliant plans are required to cover these evidence-informed pediatric preventive care and screening guidelines.[21]

Rehabilitative and Habilitative Services and Devices

Like pediatric dental and vision services, habilitative services and devices are often insufficiently covered by the base-benchmark plan candidates and must be supplemented. Beginning in plan year 2017, issuers must, with respect to habilitative services and devices, "cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy (PT/OT) speech-language pathology (ST) and other services for people with disabilities in a variety of inpatient and/or outpatient settings."[22] Issuers may not impose "limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices," and may not impose combined limits on habilitative and rehabilitative services and devices.[23] For pediatric habilitative services and devices, coverage must be provided until at least the end of the month in which the enrollee turns 19 years old.[24]

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[19] See FAQs About Affordable Care Act Implementation (Part XXVI) (May 11, 2015).

[20] See http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf.

[21] The current guidelines can be viewed here: https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

[22] 45 CFR 156.115(a)(5)(i).

[23] 45 CFR 156.115(a)(5)(ii), (iii).

[24] 45 CFR 156.115(a)(6).

With regard to the recommended Priority Health HMO plan, this would mean that issuers must cover at least the following: 30 OT/PT visits for rehabilitative services; 30 ST visits for rehabilitative services; 30 OT/PT visits for habilitative services; 30 ST visits for habilitative services; rehabilitative devices; and habilitative devices.

Pediatric Vision and Dental Benefits

Most base-benchmark plan candidates do not provide pediatric dental or pediatric vision services. Plans that do not already include coverage for pediatric vision services must be supplemented with benefits from the FEDVIP vision plan with the largest enrollment. According to federal guidance, the only option to supplement vision benefits is the FEP BlueVision—High Option. Benefits included in this plan include eye exams, lenses, frames, and contact lenses, subject to certain frequency and maximum benefit limitations. Similarly, the State must supplement pediatric dental benefits from either the federal MetLife Federal Dental Plan—High Option, or Michigan's CHIP program (MIChild).

Mental Health Parity

All of the base-benchmark plan candidates offer some mental health, behavioral health, and substance abuse services. Some of the base-benchmark plan candidates, because they were issued prior to 2014, impose limitations on these services. However, many of these limitations are no longer permitted under the MHPAEA. The ACA requires all base-benchmark plans to be supplemented to be compliant with the MHPAEA. Under the MHPAEA, cost-sharing (e.g., deductibles and copayments) and treatment limitations (e.g., visit or day limits) applicable to mental health/substance use disorder benefits can be no more restrictive than the cost-sharing and treatment limitations applicable to medical/surgical benefits covered by the plan. In addition, the plan may not impose separate cost-sharing requirements or treatment limitations that apply only with respect to mental health/ substance use disorder benefits.

Accordingly, in any instance in which the base-benchmark plan does not comply with the MHPAEA, DIFS will modify the plan so that its coverage for mental health, behavioral health, and substance abuse services complies with the MHPAEA.

Prescription Drug Benefits

Federal regulations require issuers to cover the greater of: 1) one drug in every United States Pharmacopeia category and class; or 2) the same number of prescription drugs in each category and class as the EHB base-benchmark plan. The issuer must also have in place an "exceptions process" in which an enrollee may request and gain access to clinically appropriate drugs not otherwise covered by the plan.[25] In addition, as of 2017, issuers will be required to use a pharmacy and therapeutics committee that meets certain federal standards.[26]

Next: Public Comments →

[25] 45 CFR 156.122(c).
[26] 45 CFR 156.122(a)(3).

Public Comments

DIFS received 19 comments from various organizations and Michigan citizens on the ten base-benchmark plan candidates. This section of the report addresses and responds to every topic raised in the public comments.

Numerous commenters asked that ***transgender health care***, including but not limited to hormone replacement therapy and surgery, be included as an essential health benefit. Of the ten benchmark plan candidates, only two offer limited coverage for transgender services: BCBSM Community Blue PPO Plan 4 and BCBSM Simply Blue 2500 (for reconstructive procedures of the genitalia only). None of the lowest-cost plans (small group and HMO plans) cover transgender services. In its efforts to choose a lower-cost plan, DIFS was unable to select a plan that included coverage for transgender services.

DIFS notes that while Section 1557 of the ACA prohibits discrimination on the basis of gender identity and sex stereotyping, HHS has stated that this section does not require issuers to cover transition-related surgery.[27] Similarly, DIFS notes that, in the absence of a legislative mandate, DIFS cannot require issuers to provide benefits other than in the areas specifically identified for supplementation (see pp. 7-10, above). However, Section 1557 of the ACA[28] does prohibit issuers from discriminating on the basis of gender identity for services that are already covered by a plan. For example, recent guidance issued by HHS notes that it is impermissible for a plan or issuer to limit sex-specific recommended preventive services (e.g., mammograms, pap smears, contraceptives) based on an individual's sex assigned at birth, gender identity, or recorded gender.[29] To ensure compliance with federal and state law, DIFS will review policy forms for similar types of impermissible exclusions. DIFS will continue to monitor this issue closely.

One commenter requested that the selected base-benchmark provide benefits for ***cardiac rehabilitation***. All of the base-benchmark plan candidates provide coverage for some degree of cardiac rehabilitation, pursuant to the terms of the particular plan document. Where specific visit limits are not noted on the chart (see Appendix B), cardiac rehabilitation is provided without visit limits, but may still be subject to other limitations within the policy. Non-visit limits (such as the requirement that cardiac rehabilitation services must require intensive monitoring or supervision) are not part of the EHB package and may be omitted or altered by issuers.

Some commenters noted that the base-benchmark plan would be required to comply with the newly-adopted federal standard for ***habilitative services and devices***. As noted above, DIFS intends to apply this standard beginning with plan year 2017, as well as the requirement that habilitative services and devices be provided at parity with rehabilitative services and devices

[27] See Office for Civil Rights, Questions and Answers on Section 1557 of the Affordable Care Act, Question #5, August 6, 2012 (no longer accessible via the HHS website).
[28] 42 USC § 18116.
[29] See FAQs About Affordable Care Act Implementation (Part XXVI), FAQ #5 (May 11, 2015).

and not in combination. DIFS also notes that applied behavior analysis for autism spectrum disorder is mandated by state law,[30] and is considered to be a required component of Michigan's habilitative services and devices EHB category.

Several commenters requested clarification on the requirements for ***tobacco cessation*** coverage. Tobacco cessation counseling and interventions are a USPSTF category "A" recommendation and thus are required to be covered by EHB-compliant plans. The USPSTF is currently in the process of adopting updated guidelines. Accordingly, beginning with plan year 2017, DIFS will use the most current USPSTF recommendations to establish a standard for tobacco cessation coverage in EHB-compliant plans.

One commenter recommended that the base-benchmark plan candidates' ***prescription drug formularies*** be available for review. Prescription drug formularies change frequently and were not available from all of the benchmark plan candidates. In addition, as noted above, federal regulations require issuers to cover the greater of: 1) one drug in every United States Pharmacopeia category and class; or 2) the same number of prescription drugs in each category and class as the EHB base-benchmark plan. As a result, if the base-benchmark plan has fewer drugs than one in every USP category and class, it will have to be supplemented to comply with the USP standard. It should be noted that plans are not required to cover exactly the same drugs as the base-benchmark plan; they must simply cover the same number of drugs, or at least one of each drug in each USP category and class.

One commenter recommended that Michigan select a base-benchmark plan that included a ***pediatric yearly comprehensive eye examination*** as well as eyeglass/contact benefits. The only option for supplementing the pediatric vision EHB is the federal FEDVIP BlueVision High Option plan. This plan provides coverage for an annual eye examination for adults and dependent children, as well as eyeglass and contact benefits. The benefits contained in this plan will become part of Michigan's EHB benchmark plan. The full range of benefits under this plan is available by clicking on the link to the plan in the chart at Appendix B.

With regard to devices, all base-benchmark plan candidates provide some durable medical equipment benefits. The specific devices covered will vary among plans. Some commenters requested that a plan with ***hearing aid coverage*** be selected. Although hearing aids are generally a low-cost item, none of the lower-cost plans (the small group and HMO plans) provide hearing aid coverage. In its efforts to choose a lower-cost plan, DIFS was unable to select a plan that provided hearing aid coverage and affordability. DIFS notes that issuers are permitted to add additional benefits beyond those offered in the benchmark plan.

Several commenters advocated for the selection of a particular plan, including some commenters who recommended that ***Priority Health HMO plan*** be chosen again as the base-benchmark plan in order to maintain consistency. As noted above, the Priority Health HMO

[30] MCL 500.3406s.

plan that is included in this year's array of base-benchmark candidates differs in certain respects from the 2014 Priority Health HMO benchmark. Accordingly, the selection of the Priority Health HMO plan will not be exactly equivalent to the base-benchmark plan in place for 2014 through 2016, although it will be similar.

One commenter suggested that one of the ***state employee plans*** be chosen because these plans provide fewer limitations on mental and behavioral health services. DIFS notes that any non-quantitative exclusions in the base-benchmark plan candidates are not part of the EHB package and may or may not be adopted by other issuers. Accordingly, any exclusions present in the selected plan will not necessarily become part of other EHB-compliant plans; and selecting a plan with fewer non-quantitative exclusions would not mandate the elimination of exclusions in other plans.

Two commenters recommended that the ***"leanest" health plan option*** be chosen, in order to maintain affordability.

Next: DIFS' Recommendations →

DIFS' Recommendations

Benchmark Plan Recommendation

DIFS recommends that the Priority Health HMO plan be selected as Michigan's benchmark plan for plan year 2017. This plan is substantially similar to Michigan's previous benchmark plan.[31]

DIFS adhered to certain guidelines in developing a benchmark plan recommendation; namely, that the recommended benchmark plan should:

- Include coverage for all Michigan-mandated services; and
- Provide comprehensive coverage while maintaining affordability.

In addition, DIFS took into consideration the following:

- Public comments;
- Scope and duration limitations for covered benefits; and
- Consistency with current benchmark plan.

With regard to plan cost differences, DIFS staff examined the variations in benefits among the various benchmark plans to assess the potential cost differences. Because HHS permitted an extension of the transitional plans for small group, most of the benchmark options were consistent with the 2012 Wakely study. Therefore, DIFS relied upon the Wakely study in its evaluation of the plans.

The Wakely study identified premium differences for certain benefit categories.[32] DIFS staff compared the plans in the context of these cost estimates and, as was the case in 2012, determined that the Priority Health HMO plan would likely be the least costly, particularly in the high-cost categories of adult dental, infertility, and physical therapy/occupational therapy/speech therapy.

As in 2012, in developing the benchmark recommendation, DIFS focused on achieving a balance between ensuring that all EHB requirements are met and mitigating rate increases. DIFS believes that the selection of the Priority Health HMO plan achieves the best balance between comprehensiveness and cost-effectiveness for Michigan consumers. DIFS also believes that, given the substantial similarity between the 2012 benchmark plan and the 2017 benchmark plan, this selection will promote continuity in the individual and small group markets.

Pediatric Dental Benefits Recommendation

As in 2012, DIFS recommends that the pediatric dental benefits category be supplemented using benefits from the MIChild dental program. This program is comprehensive and has a

[31] The 2017 Priority Health HMO plan differs from the 2012 Priority Health HMO plan in the following respects: 1) it clarifies coverage for autism spectrum disorder treatments; 2) it clarifies coverage for women's preventive services; 3) it eliminates coverage for men's contraceptives; 4) it changes the formulary from closed to open; 5) it clarifies coverage exclusions for developmental delays and cognitive disorders.

[32] See p. 12 of the Wakely study, which may be viewed here.

proven record of meeting the pediatric dental needs of Michigan children. In addition, the continued use of the MIChild plan will ensure consistency and avoid disruptions between plan years 2016 and 2017.

Pediatric Vision Benefits Recommendation

As noted above, benchmark plans that do not already include coverage for pediatric vision services must be supplemented with benefits from the FEDVIP vision plan with the largest enrollment. According to federal guidance, the only option to supplement vision benefits is the FEDVIP BlueVision—High Option plan. Accordingly, DIFS recommends the selection of this plan to supplement the benchmark plan.

Appendix A
State of Michigan
Essential Health Benefits Selection
Notification Letter to Secretary Burwell

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

BRIAN CALLEY
LT. GOVERNOR

June 29, 2015

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Via U.S. Mail and email: EHBQuestions@cms.hhs.gov

Dear Secretary Burwell:

Pursuant to section 1302(b)(2)(A) of the federal Patient Protection and Affordable Care Act (ACA), I am writing to inform you that the Priority Health HMO plan has been selected as Michigan's essential health benefits benchmark plan for coverage year 2017. This plan – as supplemented by the MIChild dental program (for pediatric dental coverage) and the federal FEDVIP BlueVision High Option plan (for pediatric vision coverage) – will form the minimum coverage requirements under the ACA for Michiganders in the non-grandfathered small group and individual insurance markets for plan year 2017.

Please note that Michigan requested, and received, from the Center for Consumer Information and Insurance Oversight, an extension of the deadline to select its benchmark plan. Accordingly, Michigan is submitting this selection letter to you on the extended deadline date of July 1.

It is important to note that Michigan selected its essential health benefits benchmark plan based on the guidance presently available from the federal government on essential health benefits and the benchmarking process. Based on this guidance, the selection of the Priority Health HMO plan as Michigan's essential health benefits benchmark plan is expressly limited to plan year 2017 and may be reevaluated at a later date.

Staff from the Michigan Department of Insurance and Financial Services will enter the coverage details for Michigan's benchmark plan selection into the U.S. Department of Health & Human Service's Health Insurance Oversight System (HIOS).

Sincerely,

Rick Snyder
Governor

Appendix B
Michigan Base-Benchmark Plan Options Comparison Chart

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits provided by potential benchmark major medical plans - data as of 3/31/14

Grouped in the 10 categories of Essential Health Benefits required by the ACA.

http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

	Small Group			*HMO*	*State Employee Plans*			*Federal Employee Plans*			
Benefits	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	***Michigan Mandate***
1. Ambulatory patient services - EHB Category											
Primary Care Visit to Treat an Injury or Illness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Specialist Visit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Surgery Physician/Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Home Health Care Services	Yes	Yes	Yes	Yes	Yes	Yes limited to 60 visits per calendar year	Yes	Yes	Yes	Yes - 50 visit limit	500.3519(3)
Hospice Services - home	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes - $15,000 limit	500.3406c
Breast Cancer Outpatient Treatment Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406d
Abortion for Which Public Funding is Prohibited	No	No	No	No	No	No	No	No	No	No	Act 182 of 2013
Chemotherapy (Antineoplastic)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406e
Radiation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Dialysis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Infusion Therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
2. Emergency Services - EHB Category											
Emergency Room Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406k
Emergency Transportation/Ambulance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406l 500.3519(3)

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits	*Small Group*			*HMO*	*State Employee Plans*			*Federal Employee Plans*			
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	*Michigan Mandate*
Urgent Care Centers or Facilities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3. Hospitalization - EHB Category											
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Inpatient Hospice	Yes	Yes maximum of 45 days per contract year, combined with inpatient rehab facility, subacute facility, and skilled nursing facility	Yes	Yes maximum of 45 days per contract year, combined with inpatient rehab facility, subacute facility, and skilled nursing facility	Yes	Yes	Yes - maximum of 120 days per confinement, combined with inpatient rehab facility, subacute facility, and skilled nursing facility	Yes	Yes	Yes	
Inpatient Physician and Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Transplants	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Skilled Nursing Facility	Yes - up to a maximum of 120 days per member per year	Yes maximum of 45 days per contract year, combined with inpatient rehab facility, subacute facility, and inpatient hospice facility	Yes - up to a maximum of 120 days per member per year	Yes maximum of 45 days per contract year, combined with inpatient rehab facility, subacute facility, and inpatient hospice facility	Yes maximum of 120 days for each benefit period, in a SNF for general conditions. Period renews after 90 days	Yes - non-network benefits are limited to 100 days per year	Yes - maximum of 120 days per confinement, combined with inpatient rehab facility, subacute facility, and inpatient hospice facility	Yes	Yes	Yes - Plan pays $700/day	
4. Maternity and newborn care - EHB Category											
Prenatal and Postnatal Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
5. Mental health and substance use disorder services, including behavioral health treatment - EHB Category											
Mental/Behavioral Health Inpatient Services	Yes	Yes - 20 days per contract year **Must be supplemented**	Yes - 60 days per year **Must be supplemented**	Yes - 20 days per contract year **Must be supplemented**	Yes	Yes	Yes	Yes	Yes	Yes	500.3406b

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits	***Small Group***			***HMO***	***State Employee Plans***			***Federal Employee Plans***			
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	***Michigan Mandate***
Mental/Behavioral Health Outpatient Services	Yes	Yes - 20 days per contract year **Must be supplemented**	Yes 50 visits per year/ 120 visits - lifetime maximum **Must be supplemented**	Yes - 20 days per contract year **Must be supplemented**	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Substance Abuse Disorder Inpatient Services	Yes	Yes - 10 days per contract year **Must be supplemented**	Yes - 60 days per year **Must be supplemented**	Yes - 10 days per contract year **Must be supplemented**	Yes	Yes	Yes	Yes	Yes	Yes	
Substance Abuse Disorder Outpatient Services	Yes	Yes - 30 days per contract year **Must be supplemented**	Yes	Yes - 30 days per contract year **Must be supplemented**	Yes	Yes	Yes	Yes	Yes	Yes	500.3425 500.3519(3)
6. Prescription drugs - EHB Category											
Generic Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Preferred Brand Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Non-Preferred Brand Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Specialty Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network Retail Pharmacy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Growth Hormone Therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Infertility Treatment Prescription Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
7. Rehabilitative and habilitative services and devices - EHB Category											
Rehabilitative Services	Yes - 60 combined visits per contract year	Yes - 30 combined visits per contract year	Yes - 30 combined visits per contract year	Yes 30 combined visits w/chiro per contract year	Yes 90 Visits per member, per calendar year	Yes - 60 combined visits per contract year	Yes 90 OT/PT/St Combined visits per contract year	Yes - 75 Visits per Year/All therapies combined	Yes - 75 Visits per Year/All therapies combined	Yes - 60 visits/all therapies combined	
Habilitative Services & Devices	No **Must be supplemented**	Yes - 30 combined visits per contract year	No **Must be supplemented**	Yes - 30 combined visits per contract year	No **Must be supplemented**	Only for Autism	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	Yes	

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits	***Small Group***			***HMO***	***State Employee Plans***			***Federal Employee Plans***			
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	***Michigan Mandate***
Autism Therapy	Yes - ABA limited to annual maximum $50,000 **Must be supplemented**	Yes	Yes - ABA limited to annual maximum $50,000 **Must be supplemented**	Yes	Yes	Yes	Yes with 135 days per contract for ABA therapy **Must be supplemented**	Physical, Occupational, Speech Therapies - No ABA **Must be supplemented**	Physical, Occupational, Speech Therapies - No ABA **Must be supplemented**	No **Must be supplemented**	500.3406s Order 14-017-M
Durable Medical Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Prosthetic Devices including Mastectomy Prosthetics	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406a
8. Laboratory services - EHB Category											
X-Rays & Diagnostic Imaging	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Laboratory Outpatient and Professional Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Imaging (CT and PET Scans, MRIs)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Breast Cancer Diagnostic Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406d
9. Preventive and wellness services and chronic disease management - EHB Category											
Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network Retail Pharmacy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Preventive Care/Screening/Immunization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Routine Foot Care	No	No	No	No	No	No	No	No	No	No	
Allergy Testing	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Diabetes Education	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406p
Nutritional Counseling	Yes - nutritional therapy in Autism	Yes - six visits per contract year	Yes - nutritional therapy in Autism	Yes - six visits per contract year	Yes - this is listed under weight loss with lifetime maximum of $300	Yes - 3 sessions per year in-network only	Yes - six visits per contract year	Yes	Yes	Yes	
10. Pediatric services, including oral and vision care - EHB Category											
Basic Dental Care (Child)	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	Yes	No **Must be supplemented**	Yes	Yes	Yes	Yes	
Routine Eye Exam (Child)	No **Must be supplemented**	Screening only as part of physical exam	No **Must be supplemented**	Screening only as part of physical exam	Yes	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	Yes	

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits	***Small Group***			***HMO***	***State Employee Plans***			***Federal Employee Plans***			
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	***Michigan Mandate***
Major Dental Care (Child)	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	Yes	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	
Orthodontia (Child)	No	No	No	No	Yes	No	No	No	No	No	
Eye Glasses for Children	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	Yes	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	No **Must be supplemented**	
General Pediatric Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Well Baby Visits and Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3406n 500.3519(3)
Miscellaneous											
Accidental Dental	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	
Routine/Basic Dental Care (Adult)	No	No	No	No	Yes	No	No	Yes	Yes	Yes	
Chiropractic Care	Yes - spinal manipulation limited 24 visits - reduced to 12 visits with optional rider	Yes- 30 combined visits per contract year with rehab OT/PT	Yes - limited to 12 visits per member per calendar year	Yes- 30 combined visits per contract year with rehab OT/PT	Yes - 24 visits per member per calendar year combined in & out of network	Yes - 20 visits per year	Yes- 30 combined visits per contract year	Yes	Yes	Yes - 12 visits per year	
Cosmetic Surgery	Yes	No	Yes	No	Yes	No	No	No	No	No	
Diagnosis and treatment of infertility, e.g. endometriosis, blockage of fallopian tubes, varicocele	Yes - limited infertility services	Yes	Yes - limited infertility services	Yes	No - excluded under what is not covered	Yes - 5 office visits & 3 diagnositic/ surgical procedures annual benefit limit per covered person artificial insemination included	Yes	Yes	Yes	Yes	

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

	Small Group			*HMO*	*State Employee Plans*			*Federal Employee Plans*			
Benefits	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	***Michigan Mandate***
Hearing Aids	No	No	No	No	Yes standard or binaural once every 36 months	Yes - includes hearing aids limited to $880 for monaural or $1600 binaural once every 36 months	Yes - includes one hearing exam, one audiometric exam, and one basic hearing aid per ear every 36 months; hearing aid is limited to $500 per aid	Yes	Yes	Yes	
Long Term/Custodial Nursing Home Care	No	No	No	No	No	No	No	No	No	No	
Major Dental Care (Adult)	No	No	No	No	Yes	No	No	Yes	Yes	No	
Non-Emergency Care When Traveling Outside the U.S.	Yes	No	Yes	No	No	No	No	Yes	Yes	Yes	
Orthodontia (Adult)	No	No	No	No	Yes	No	No	No	No	No	
Private-Duty Nursing	Yes	No	Yes	No	Yes	No	Yes	No	No	No	
Routine Eye Exam (Adult)	No	Screening only	No	Screening only	Covered under Blue Vision cert	Yes	Screening only	No	No	No	
Weight Loss Programs	No	Yes	No	Yes	Yes - $300 lifetime maximum	Yes	Yes	No	No	No	
Bariatric Surgery	Yes - if medically necessary	Yes - once per lifetime	Yes - if medically necessary	Yes - once per lifetime	Yes - if medically necessary	Yes in-network only, medically necessary, order by primary care physician; one per lifetime	Yes - once per lifetime	Yes	Yes	Yes	
Acupuncture	No	No	No	No	Yes - 20 treatments per calendar year	No	No	Yes	Yes	Yes - 20 treatments per year	
Wigs and supplies (cancer or alopecia only)	No	No	No	No	Yes - lifetime maximum $300	No	No	Yes - $350 lifetime maximum	Yes - $350 lifetime maximum	No	
Genetic Testing	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Evaluation and treatment of chronic pain	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Reconstructive Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

2017 Benchmark

MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON

Benefits	*Small Group*			*HMO*	*State Employee Plans*			*Federal Employee Plans*			
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCBSM Simply Blue 2500	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	*Michigan Mandate*
Blepharoplasty of upper lids	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Breast Reduction	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Surgical Treatment of Male Gynecomastia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Rhinoplasty and Septorhinoplasty (sleep apnea treatment)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Panniculectomy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Treatment for Temporomandibular Joint Disorders	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Orthognathic Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	
Transgender/gender Reassisgnment Services	No only reconstructive procedures of the genitalia	No	No only reconstructive procedures of the genitalia	No	No	Behavioral Health Services	No				

Abbreviations: BCBSM = Blue Cross Blue Shield of Michigan; PHP = Physicians Health Plan; CT = computed tomography; GEHA = Government Employees Health Association; MRI = magnetic resonance imaging; PET = positron emission tomography; PT = physical therapy; OT = occupational therapy; ST = speech therapy

Any covered services may be subject to medical management techniques, cost sharing, etc.

The data provided in this chart is not legal advice and is intended for informational purposes only. This chart has been compiled by the Michigan Department of Insurance and Financial Services based on presently available enrollment data and benefit design, utilizing the essential health benefit (EHB) definitions and categories as delineated in the most recent guidance provided by the federal government. The U.S. Department of Health and Human Services (HHS) has directed states to choose the EHB benchmark from certain enumerated plans, including the largest HMO and small group plans in the state, identified by enrollment data as reported to HHS for the first quarter of 2014. The data provided in this chart is subject to change as additional federal guidance is provided with regard to EHB.

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

DENTAL

Benefits	*State of MI* *MIChild* *BCBSM*	*Federal Employee Plans* *FEDVIP Dental* *MetLife*
Diagnostic		
Initial exam	Yes	Yes
Routine checkup	Yes	Yes
Bitewing X-rays	Yes	Yes
Diagnostic tests	Yes	Yes
Preventive		
Cleanings	Yes	Yes
Flouride treatments	Yes under age 14	Yes up to age 22
Space maintainers	Yes under age 14	Yes
Dental sealants on first and second permanent molars	Yes	Yes
Restorative		
Fillings of amalgam, plastic composite or similar materials and stainless steel crowns	Yes	Yes
Metallic onlays	No	Yes
Porcelain or ceramic crown substrate	No	Yes
Endodontics		
Pulpotomy for primary teeth	Yes	Yes
Anterior, bicuspid and molar root canal	No	Yes
Anterior, bicuspid and molar root canal therapy	No	Yes
Periodontics		
Periodontal scaling and root planing	No	Yes
Gingivectomy or gingivoplasty	No	Yes
Prosthodontics (removable)		
Maxillary dentures	No	Yes

Benefits	State of MI MIChild BCBSM	Federal Employee Plans FEDVIP Dental MetLife
Prosthodontics (fixed)		
Porcelain, ceramic and cast metal retainers for resin bonded fixed prosthesis	No	Yes
Oral & Maxillofacial Surgery		
Simple extractions	Yes	Yes
Adjunctive General Services		
Consultation by a second dentist not providing treatment	Yes	Yes
Exams and treatment for an emergency condition	Yes	Yes
Emergency treatment for temporary relief of pain	Yes	Yes

VISION

Benefits	Federal Employee Plans FEDVIP Vision FEP BlueVision
Vision exam and glaucoma test	Yes Glaucoma test is not specifically included or excluded
Eyeglass frames (wire, plastic or metal)	Yes
Eyeglass lenses	Yes
Medically necessary contact lenses	Yes